

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-020526

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

FILED MAY 31 1962

Primary Registration District No.

1003

Registrar's No.

5177

VS 300
Rev. 4/59

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DATE AMENDED

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. Louis</i>		c. CITY OR TOWN <i>ST. Louis</i>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>3644 Winnebago</i>		d. STREET ADDRESS (If outside, give location) <i>3644 Winnebago</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>RUDOLPH L. HOLZBORN</i>		4. DATE OF DEATH Month Day Year <i>MAY 20 1962</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>2-23-1894</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Welder</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) <i>Missouri</i>		12. CITIZEN OF WHAT COUNTRY <i>U. S. A</i>	
13a. FATHER'S NAME <i>GUSTAV HOLZBORN</i>		13b. MOTHER'S MAIDEN NAME <i>LISSETTE ZINCK</i>	
14. NAME OF HUSBAND OR WIFE <i>BARBARA HOLZBORN</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>BARBARA HOLZBORN 3644 Winnebago</i>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatosis</i> <i>Carcinoma of rectum</i> <i>154X</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>4+ mos</i> <i>1 1/2 yrs +</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <i>1961 to May 62</i>		
21. I attended the deceased from <i>1961</i> to <i>May 62</i> and last saw him alive on <i>May 62</i> Death occurred at <i>12:45 p.m.</i> on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <i>Phyllis Smith MD</i>	
22b. ADDRESS <i>3915 Watson Rd St Louis 9</i>		22c. DATE SIGNED <i>22 May 62</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>	23b. DATE <i>MAY 23, 1962</i>	23c. NAME OF CEMETERY OR CREMATORY <i>ST. PAUL CHURCHYARD</i>	23d. LOCATION (City, town, or county) (State) <i>ST. LOUIS MO.</i>
24. FUNERAL DIRECTOR <i>Thomas Kutsis 2906 Harris</i>		25. DATE RECD. BY LOCAL REG. <i>MAY 22 1962</i>	
26. REGISTRAR'S SIGNATURE <i>Joan Smith. M.D.</i>		27. REGISTRAR'S SIGNATURE <i>Joan Smith. M.D.</i>	

USE BLACK INK
OR
TYPEWRITER RIBBON

*Pls. Henry
Southwest Medical Center*
MS 7 4221
9-11:30 - 1:30 - 5

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body-whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *La. Humphrey*

Licensed Embalmer No. *4772*

P. O. Address *2906 Gables*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.